MARIJUANA AS SCAPEGOAT, CANNABIS AS MEDICINE:

A COGNITIVE-RHETORICAL ANALYSIS OF A CANADIAN DRUG-POLICY PROBLEM

by

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ABSTRACT

This thesis examines the remarkable ambivalence towards Cannabis sativa L. in Canada, evidenced in the high-stakes contest between competing public conceptions of, and private interests in, the drug-plant and cash crop. Official policy regarding the enigmatic substance over the first decade of the 21st century has been notably erratic, and during this period a number of dramatic shifts in Canada's administrative and clinical approaches to cannabis have occurred. This has resulted in changes which stand out significantly in the history of the plant's medicinal, recreational, and industrial use in this country.

Despite the recent surge in acceptance and legitimacy of its medical use in a number of jurisdictions, the definition, classification, regulation, prescription, cultivation, marketing, and consumption of cannabis for therapeutic purposes continue to pose, for many groups and individuals in this country, a medico-legal dilemma—with the boundary between licit and illicit a blurry one in deed, and in word. The many lingering questions about proper ethical and practical conduct within (and parallel to) the framework of the MMAR have made it exceedingly difficult for many participants to arrive at a comfortable fit between the activities pursuant to their roles and the uncertain, unqualifiable, or unappreciated value (or risk) entailed by those roles.

I intend not only to improve understanding of the rhetorical, linguistic, and socio-cognitive basis of a particular drug-policy problem, but also to demonstrate, in so doing, the broad analytical reach of rhetorical theory and criticism, and the usefulness of applying rhetorical and cognitive-linguistic methodologies together. Through analysis of suasive elements of key terms and conceptual structures in the discourse, and of differently motivated role-value connections assumed by participants therein, I forward the claim that marijuana has played the part of the scapegoat in medicine and, more broadly, among all drugs.

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To the many and diverse agents

acting practically and symbolically to normalize

the use of cannabis in Canadian society and medicine.

INTRODUCTION

My thesis examines the remarkable ambivalence towards *Cannabis sativa L.* in Canada, evidenced in the high-stakes contest between competing public conceptions of, and private interests in, the drug-plant and cash crop. Official policy regarding the enigmatic substance over the first decade of the 21st century has been notably erratic, and during this period a number of dramatic shifts in Canada's administrative and clinical approaches to cannabis have occurred. This has resulted in changes which stand out significantly in the history of the plant's medicinal, recreational, and industrial use in this country (see, e.g., Le Dain et al., 1972; Nolin et al., 2003).

Despite the recent surge in acceptance and legitimacy of its medical use in a number of jurisdictions, the definition, classification, regulation, prescription, cultivation, marketing, and consumption of cannabis for therapeutic purposes continue to pose, for many groups and individuals in this country, a medico-legal dilemma—with the boundary between licit and illicit a blurry one in deed, and in word. Cannabis continues to occupy the paradoxical position of both dangerous illicit substance with no established medical value (see, e.g., Canada's *Controlled Drugs and Substances Act* [*CDSA*]), and a comparatively safe and sanctioned remedy, uniquely effective in treating certain medical conditions (see, e.g., Canada's *Marihuana Medical Access Regulations* [*MMAR*]).

Purpose and Scope

Pronounced discrepancies in policy (among other, broader, geopolitical factors) have hindered progress in the debate around the normalization of cannabis in clinical practice, and thus far prevented the drug's official reinstatement into official Canadian drug formularies. Further, the many lingering questions about proper ethical and practical conduct within (and parallel to) the

framework of the *MMAR* have made it exceedingly difficult for many agents[1]—physicians/prescribers, producers/suppliers, and patients/users—to arrive at a comfortable fit between the activities pursuant to their roles and the uncertain, unqualifiable, or unappreciated value (or risk) entailed by those roles[2].

This thesis intends not only to improve understanding of the rhetorical, linguistic, and socio-cognitive basis of a particular drug-policy problem, but also to demonstrate, in so doing, the broad analytical reach of rhetorical theory and criticism, and the usefulness of applying rhetorical and cognitive-linguistic methodologies together. Through analysis of suasive elements of key terms and conceptual structures in the discourse, and of differently motivated role-value connections assumed by participants therein, I forward the claim that marijuana has played the part of the *scapegoat* in medicine and, more broadly, among all drugs. It may even be fair to say that cannabis has become in our society emblematic of the *pharmakos*, the ancient Greek version of the sacrificial/redemptive scapegoat figure and ritual—the paradoxical embodiment and enactment of both innocence and culpability, signifying both purity and contagion.

In accordance with philosopher and critical theorist Jacques Derrida's explanation of drugs as a natural kind of pharmakos, cannabis is held to be a substance that is somehow "both … antidote *and* … poison" ("Rhetoric…" 25)[3], both licit medicine and illicit drug. Derrida

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[1] I adopt the five master terms of Kenneth Burke's "dramatistic pentad": scene, act, agent, agency, and purpose (Burke *Grammar* xv). Active participants in the medical cannabis scene—in other words, agents—include political and bureaucratic authorities; medical professionals; medicinal-cannabis producers, distributors and connoisseurs; and cannabis-requiring patients.

[2] See, e.g., Nolin and Kenny 2003; Capler 2007; Zettl in Rollanson 2009; Mulgrew 2008; Young in Kari 2009 for a selection of commentary critical of the *MMAR*.

[3] Cf. Thomas Szasz's treatment of drugs-as-*pharmakos*. The psychiatrist and outspoken critic of biomedical scientism uses the similar antithetical terms "panacaea" and "panapathogen" (*Ceremonial*… 137).

addresses the liminal, almost inexplicable, position of psychotropic substances within the inventory of human cultural artefacts[4]:

> The concept of drugs supposes an instituted and an institutional definition: a history is required, and a culture, conventions, evaluations, norms, and entire network of intertwined discourses, a rhetoric, whether explicit or elliptical. …[O]ne must conclude that the concept of drugs is not a scientific concept, but is rather instituted on the basis of moral or political evaluations: it carries in itself both norm and prohibition, allowing no possibility of description or certification…." ("Rhetoric…" 20)

Judy Segal, a rhetorician of health and medicine, explains her own discipline's value in dealing with tough socio-epistemic issues pertaining to the discussion and treatment of illness. She claims that "[r]hetorical analysis promises to be especially useful in the case of … intractable problems, where standard accounts inside biomedicine itself … have failed to be sufficiently explanatory" ("Illness…" 233).

The conundrum of cannabis in medicine is, I hold, such an "intractable problem," the crux of which is less scientific than conceptual, discursive, rhetorical and socio-linguistic. My thesis strives at a useful explanation of the role of cannabis in society and medicine, and seeks to demonstrate the profitability of a rhetorical analysis of the language of medicine and drugs. Such analysis, Segal affirms, "suggests countless opportunities to reflect on health and medicine's complexity" (*Health* 156-7).

My work is limited in scope, geographically and chronologically, to the Canadian cannabis scene during, roughly, the years 1998-2010—a particularly eventful period in this

[4] On cannabis as "biological cultural artefact" and botanical *agent*, see language philosopher Dan Sperber's (2007) treatment ("Seedless…" 134-5) of activist-journalist Michael Pollan's theory of the co-evolutionary nature of the human-cannabis relationship in the latter`s *The Botany of Desire* (2001).

country for the plant-drug. In 1998, the production of industrial hemp was legalized. In May of 1999, Health Canada issued an "Interim Guidance Document" (Nolin and Kenny 122) that initiated the process of "enabling Canadians to apply for an exemption to possess and cultivate marijuana for therapeutic purposes under the authority provided in section 56 of the *CDSA* (122)." This marked the beginning of the current era of the reintegration of cannabis into the Canadian medical system,[5] and led (among other factors) to the 2001 drafting of the *MMAR*. However, after being expelled from pharmacopoeiae, ignored by science and industry, and scapegoated by government and the establishment for so long, cannabis' smooth re-entry into medical practice has proven impossible.

Theoretical Framework and Methodology

Kenneth Burke's Rhetoric of the Scapegoat

In his analysis of the scapegoat phenomenon, in *A Grammar of Motives* (1969) prominently, and elsewhere in his work, rhetorician and literary critic Kenneth Burke provides a thorough and illuminating account of the subject. Burke understands scapegoating as a timeless and ubiquitous ritual of purification, a socially symbolic act of "vicarious atonement" (*Grammar* 406) based on the cognitive processes *antithesis* (a category of definition) and *substitution* (a category of change). It is a fundamentally "dialectic" procedure (406), he argues, a transformational function that may hinge on the contrastiveness inherent in various terminological dichotomies, or "antinomies of definition" (21), such as "disease-cure" or "hero-villain" (512). Neither member of these pairs would bear meaning if not for its opposite term[6]. There can be no cure without a

[5] Cannabis was included in Western pharmacopoeiae roughly between the early 1800s and the early 1900s, with its therapeutic use peaking between 1880 and 1900 (see, e.g., Iversen 116-22).

[6] A similar concept, espoused by rhetorical theorists Chaim Perelman and Lucie Olbrechts-Tyteca, is that of "philosophical pairs" ("Classicism…" 74-6).

disease, no hero without a villain. A hallmark of the surrogate victim selected by a group as scapegoat is that *both* terms of particular antinomies may be held to be definitive of this individual simultaneously, and paradoxically. As Burke puts it, "[a]s an essence of motivation, the scapegoat is a concentration of power, hence may possess the ambiguities of power, which may be for either good or evil" (*Grammar* 407). Reviled toxin, revered tonic and valuable cash-crop, cannabis is multi-faceted in character, and powerfully ambiguous in significance.

Scapegoating is, most basically, a version of one of humans' oldest symbolic enactments: the ritual of group purification by individual sacrifice. The tendency to victimize, to scapegoat, is ubiquitous and inevitable, and Burke warns that its direst outcome is war—both martial and socio-political, or symbolic (e.g., a war on drugs, obesity, homosexuality, homelessness, etc.). Though particular instances of scapegoating may differ widely in terms of context or apparent function, Burke insists that the ritual unfolds according to a generic symbolic schema, a more-or-less scripted, three-part dramatic procedure he dubbed "The Dialectic of the Scapegoat" (*Grammar* 406).

The scapegoated figure—though alienated or annihilated—nonetheless retains, in the collective memory, an elemental sameness with, or symbolic link to, the persecuting group. Ironically, the surrogate victim may even come to be conceived of unconsciously as the epitome of its victimizers. This functional mutuality between, and dialectical co-implication of, scapegoat and scapegoater is a prime instance of what Burke calls the "paradox of substance" (*Grammar* 21).

Important to my claims is the notion of *liminality*: the concept, quality or ability of inter-domain transit or co-occupation—boundary-crossing or boundary-straddling. I investigate the apparent preoccupation in the cannabis discourse with the stigma, responsibility, and risk

associated with acts of *transgression*, a socially and morally evaluative type of liminality. The scapegoat, in a transgressive act either penitent (to make up for past ill) or proleptic (to ward off future ill), or some admixture of both, bears the group's iniquities across the threshold of the familiar realm (the intrinsic) into the realm of the unfamiliar (the extrinsic). Thus, a kind of atonement-by-proxy is performed, via the seemingly magical processes of dialectic conversion and *synecdochal* representation (see Burke *Grammar* 512). Insofar as it holds the promise of a group's redemption, scapegoating possesses a powerful "dialectic appeal" (Burke *Rhetoric* 140-1) whereby the cure may be implicit in the disease, the redemption implicit in the crime.

Cognitive-linguistic Schema Theory

While the details of linguistic and conceptual form and meaning have been the traditional focus of cognitive-linguistics, socio-cultural and rhetorico-pragmatic perspectives have in recent years begun to receive greater attention from scholars in the field (see, e.g., Dirven, Frank, and Pütz, eds., 2002). The rudimentary cognitive templates called "image schemas," first articulated by the philosopher and cognitivist Mark Johnson, have emerged as broadly useful, if still inchoate, theoretical notions. He has defined an image schema as a "dynamic recurring pattern of organism-environment interactions" that "will often reveal itself in the contours of our basic sensory-motor experience" (*Body*... 19). Not all cognitive schemas are spatial, or spatio-temporal (though many are); some present force-dynamic relationships between entities (Johnson 1987; Talmy 2000). Among the most basic, or "primitive," image-schemas identified, are CONTAINER, UP-DOWN, CENTRE-PERIPHERY, and SOURCE-PATH-GOAL.

Cognitive linguist Michael Kimmel expounds the theoretical versatility of cognitive schemas, arguing that they "constitute an important notional interface between disciplines by reaching out into neural, experimental and linguistic research while also being apt for addressing

cultural facets" ("Culture…" 102). Cognitive schemas, I hold, offer a useful way of describing the persuasiveness of the symbolic procedures of scapegoating.

Scapegoating as "Representative Anecdote" and Epideictic Occasion

Burke emphasizes the constitutive, or determinative, function in the linguistic domain of the "representative anecdote"[7] (*Grammar* 59), his notion of a programmatic model or structuring paradigm. He explains that

> the vocabulary developed in conformity with this form can possess a systematically interrelated structure, while at the same time allowing for the discussion of human affairs and the placement of cultural expressions in such typically human terms as personality and action (two terms that might be merged in the one term, "role." (60)

In the present work, I apply Burkean theories and terminologies of dramatism, motivism, and dialectical change, largely, to study the figure of cannabis-as-scapegoat in the Canadian medical system and wider public drugs discourse, as well as analyze particular roles played by agents in the medical-cannabis scene. Overall, I take the generic scapegoat phenomenon to be the representative anecdote informing the particular case of cannabis in medicine.

As the target at which a group projects its own suffering, self-pity and frustration, the scapegoat arises urgently from a public's desire to blame someone, or something, for whatever may be the looming or enduring ill. By blaming a surrogate victim, a group attempts absolution in the face of insolubility via what Burke calls "an error of interpretation" (*Permanence* 14), in which the cause (for a natural disaster, plague, war, or pervasive social problem, such as drug addiction, bullying, racism, etc.) is attributed to a single, "charismatic" (406) agent. The

[7] Burke also uses the similar, though contrastive, term "informative anecdote" (*Grammar* 59-60). An informative anecdote, like a representative anecdote, provokes and structures a particular lexicon; however, only the latter prompts faithful terminology possessing sufficient scope to represent its subject.

scapegoat dialectic is both causally tautological and teleologically curative; the scapegoat is symbolically perpetrator, victim and redeemer at once.

Social emotions constitute the forms and expressions of epideictic rhetoric, a rhetoric of the present, aimed at defining and adjusting a community's values. Such rhetoric is performed most patently in acts of praising or blaming. Segal holds that "[e]pideictic rhetoric is a culture's most telling rhetoric" ("Epideictic…" 61). As an extreme occasion of both blame and praise, revilement and reverence, disavowal and emulation, scapegoating becomes a stark example of epideictic rhetoric,[8] and a troubling clue to questions of cultural authority and social justice.

Chapter Outline

My thesis is composed of three principal chapters. Each chapter selects objects for analysis that attest to cannabis' identity as a scapegoat figure. Mostly, these selections are negative, or "dyslogistic" (Burke *Symbols* 185), linguistic expressions (and their socio-cognitive underpinnings) salient in the cannabis discourse that have "developed in conformity with" (Burke *Grammar* 60) the representative anecdote of scapegoating. Also considered are problematic issues of *ethos* and *praxis* that make safe or conscientious participation in the Canadian medical-cannabis scene difficult for those involved in it. I examine perceptions and challenges of risk-assumption and role-fulfilment that face agents operating within (and parallel to) the sanctioned occupational and regulatory framework of the Canadian medical-cannabis scene.

The first chapter examines rhetorical aspects of the roles of physician and cannabis-requesting patient. The second chapter reveals the socio-cognitive representations underlying

[8] Aristotle held that the prime occasion for epideictic rhetoric was the funeral oration (see, e.g., Segal "Epideictic…" 61). In comparison, Burke claims that a type of death and rebirth is either explicit or implicit in the scapegoating dialectic of antithesis and substitution (*Grammar* 427).

metaphorical language that scapegoats cannabis. The third chapter studies the differently motivated roles of medicinal-cannabis producers and suppliers, and health department officials who manage the *MMAR*. It also addresses the symbolic, rhetorical, and political importance of scenic elements in the acts of cultivating and distributing the drug for therapeutic purposes.

I engage three primary sources for linguistic data: Canadian print journalism; items pertaining to cannabis published in the *Canadian Medical Association Journal* (*CMAJ*); and various official literatures intended as regulatory, organizational, instructional, or operational information. All data were garnered from texts authored and published, or otherwise made available publicly between 1998 and 2010.

CHAPTER ONE

"Liable Gate-keepers, "Unwanted Patients," and the "Trojan Horse":

Risk, Stigma, and Transgression in the Medicalization of Cannabis

Introduction

The central claim of my thesis is that cannabis/hemp/marij(h)uana has been, and remains, a scapegoat—a *pharmakos*—among drugs in general, and within the Western compendium of medicinal substances in particular. This chapter examines aspects of, and challenges to, the medicalization of cannabis in Canada over roughly the last decade. I am interested in how the various participants in the medical cannabis scene, the agents, assume and carry out their various and interrelated roles, each motivated by a unique concatenation of interests, affiliations, obligations, opinions, beliefs, values, hopes, and concerns. Key roles in the medical-cannabis scene include political and legal authorities, medical professionals, medicinal-cannabis producers, distributors and connoisseurs, as well as cannabis-requiring patients.

For Kenneth Burke, "[a] human role […] involves properties both intrinsic to the agent and developed with relation to the scene and to other agents" (*Grammar* 511-12). In particular, I consider two roles in this chapter, those of physician and patient. In each case, I examine ways in which the contingencies and exigencies of the medical-cannabis scene determine, in large part, the degree to which different agents are able, or willing, to perform faithfully the activities pursuant to their different roles—the degree to which, as Burke put it, "the scene contains the agents" (*Grammar* 3).

Considered scenically, then, scapegoating is at base a simple ritual drama—a proto-narrative script followed only semi-consciously by the agents in the act—by which the purification, or redemption, of a distressed and reactionary public is played out symbolically

through the victimization of a fatally "charismatic" (Burke *Grammar* 406) individual. The marks of victimhood are always observable in cases of scapegoating—not only in the character of the scapegoat, but also sometimes, and less obviously, in the characters of the victimizers as well.

In his "Open letter to the Health Minister" of 8 November 2001, George Haddad, then-president of the Canadian Medical Association, protests the imposition on doctors of the undesired role of "gatekeeper" under the newly instated *MMAR*. He complains that the *Regulations* "compel physicians" to deal in their practice in "an unproven drug, without any guidelines for its use, while at the same time being exposed to full liability for its use" (2001). In an *Ottawa Sun* article of 12 January 2008, journalist Christina Spencer conveys a sample of negative responses by physicians to an anonymous survey commissioned by Health Canada gauging the tenor of reception of the *MMAR* by the medical profession. Doctors are worried that, if their peers were to discover that "they prescribed medical marijuana, they would receive an 'influx of unwanted patients' and might suffer some professional or social stigma in the wider medical community" (Spencer 2008). At least some of the doctors questioned in the survey, all of whom had prescribed cannabis to patients under the *MMAR*, apparently feel threatened in their participation in the program.

So, more than six years after Haddad's protest letter to Health Canada, physicians continue to decry their perceived victimization under the terms of the *MMAR*. Aside from fears of their liability for dealing in an "unproven" drug, there is also a fear among physicians, it seems, of being "found out" by their professional peers or overseers—and thus stigmatized—for participating in Health Canada's controversial cannabis-prescription and licensing regimen. Undeniably, the *MMAR* is a framework whose policies have been widely criticized as onerous and forbidding (see,

e.g., Haddad for the CMA, 2001; Nolin and Kenny, 2003; Mulgrew, 2005; Capler and Lucas, 2006; Capler, 2007; Kisely, 2008; Hall and Room, 2008).

Ironically, at least one physician, whose short quotation is featured by Spencer, seems oblivious to his or her own stigmatization of cannabis-requesting patients, bluntly labelling them "unwanted," and dreading an "influx" of this undesirable type—a virtual invasion of enemy patients, or risky clientele. That doctors should want, or at least admit to wanting, some *types* of patient rather than others is a revelation likely to be disturbing to patients whose conditions, or preferred treatments for such conditions, are contested within medicine.

Within the medical-cannabis debate, the drug has been conceived of metaphorically by prohibitionists as a "Trojan horse."[9] At the 2003 International Symposium on Cannabis in Stockholm, Sweden, Antonio Maria Costa, Executive Director of the United Nations' Office on Drugs and Crime, marshalled the metaphor in his address: "[E]ither we are serious about the medical properties of cannabis…or it is just a matter of using such properties as a Trojan horse to reach other goals—namely the *de facto* decriminalization of its production and trafficking" (in Grinspoon *Medical* 75). By this cautionary epithet, the drug's proponents are portrayed as using its medical properties as a ruse to achieve an ulterior motive, as a rhetorical and legalistic lever to loosen the restrictions on the recreational use of cannabis, with the goal of forcing its total legalization and, ultimately, the legalization of all drugs.[10]

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[9] The Trojan horse metaphor is a linguistic instantiation (taken from Homer's *Odyssey*) of an underlying conceptual metaphor that pervades the drug-prohibitionist literature of the "War on Drugs": DRUGS-AS-ENEMY INVADERS (see Montagne 20). It evokes the scenario of a fortified citadel under siege, and highlights the risk of an enemy's choice of a covert, or surreptitious stratagem of invasion.

[10] Though perhaps unarticulated, the end-goal of establishing a free and legal market for all currently illicit drugs is taken by the more sabre-rattling of the drug-warriors to be implicit in the agenda of the cannabis lobby. This is the same "slippery slope" fallacy used by the same people in their depiction of cannabis as a "gateway" drug: its use (or its legalization) portends the subsequent use (or legalization) of other, "harder" drugs.

Cannabis as *Pharmakos*

Anthropologist Andrew Sherratt defines "drug" as "a category of substances taken into the human body for purposes other than nutrition…" (1). Our contemporary conception of drug use, he explains, "encompasses two broad areas of meaning: medicinal preparations and chemically similar compounds consumed primarily for hedonistic purposes…" (1). These two subcategories of usage—the therapeutic and the recreational—are most often held in diametric opposition under the law. The former behaviour is condoned, while the latter typically is "characterized as drug 'abuse'" (1), deserving of punitive sanctions.

Peter Davis, a scholar of medicine and public health, comments on the powerful and mixed attraction drugs, or medicines, exert on people. Such substances, he writes, "are profitable commodities that are potentially toxic, but that also have the power to heal" (7). They are therefore readily, and often heavily, imbued with "moral and symbolic ambiguity" and surrounded by "[c]ompeting discourses of commercial endeavor and lofty social and political purpose…" (7). Because of the potential dangers many medicines and drugs do present (e.g., addiction, overdose, adverse or allergic reaction), public discussion of these liminal substances tends to dwell on the risks they pose, or seem to pose, to the individual or the public.

Dorothy Nelkin, a sociologist of science, states that "[t]he rhetoric of risk is full of exaggerated dichotomies…" (xi), conceptions and terminologies "frequently tied to contested social and political issues" (ix). Social anthropologists Barbara Harthorn and Laury Oaks study the social meanings of risk, and they argue that "controversies over health risk and uncertainty" characteristically are "discourses and practices that mobilize fear, blame, trust, and control…" (4). As I will show, much of the argumentation in the discourse around the medicalization of cannabis follows suit.

The protracted debate has been heated, and assessments of the drug's risks and benefits tend towards the polarized and simplistic. Dr. Wayne Hall, a leading expert on cannabis, labels the debate "an 'inflationary–deflationary dialectic,' in which cannabis problems have been both demonised by moralists and belittled by pro-cannabis organisations" (158). Without explicitly identifying cannabis as scapegoat, Hall nevertheless describes classic conditions of scapegoating in the cannabis discourse. Such conditions constitute a "victimage rhetoric" (Mackey-Kallis and Hahn 2) that begins with the blaming (and actual or symbolic sacrifice), but ends with the praising (and even totemization or worship) of the scapegoat-cum-martyr.

Cannabis has been described at particular times and places as either a panacaea, a cure-all or "wonder drug,"[11] or else a "panapathogen,"[12] a social menace and insidious "gateway drug"[13] that causes addiction to more harmful drugs, or even insanity[14]. Though it may not be a "wonder drug," the plant and its numerous active compounds provide many and varied therapeutic effects.

Apart from its recent use as a legally sanctioned medicine, its use as a social drug has exploded over the last century. Marijuana is today the most heavily consumed illicit drug in the world (Leggett and Pietschmann 189). In North America, the underground cannabis industry is currently in the grip of international crime syndicates, with heavy cross-border traffic occurring notoriously from British Columbia to The United States (see, e.g., Mulgrew 99-100). And considering its entanglement in the exponentially more lucrative and harmful cocaine traffic,

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[11] See Dr. Lester Grinspoon's article "Marijuana as Wonder Drug" (2007).

[12] This is Thomas Szasz' term for the opposite of a panacaea (Szasz, 2003).

[13] The "gateway drug" theory, and epithet for cannabis, was first promulgated by Robert L. DuPont, founding director of America's National Institute on Drug Abuse (NIDA) (DuPont, 1984). He proclaimed as recently as 2004 that "the connection of pot use to other illegal drug use is clear and indisputable" (DuPont in Sabet 330). For further support of the gateway theory for cannabis, see also Kandel, Yamaguchi, and Chen (1992); Golub and Johnson (1994); Sabet (2007).

[14] See, e.g., journalist Margret Kopala's October, 2007 editorial in the *Canadian Medical Association Journal* (CMAJ), "Reefer Madness" (177:8).

carried out by the same syndicates but flowing in the opposite direction, marijuana is conspicuously "marked." It is a transgressive substance of ambivalent symbolic and economic power, both licit and illicit, safe and dangerous, both palliative treatment and dangerous drug.

While a likely majority of Canadians acknowledges that its therapeutic or casual use poses a remarkably small health risk for the user (see, e.g., Nolin and Kenny 101-5), cannabis continues to be treated ambiguously. It is both familiar, or intrinsic (an important domestic product), and foreign, or extrinsic (a notorious commodity for export). It is an asset for some, a liability for others. The possession of even small amounts of cannabis nevertheless continues to pose a significant legal risk for most users, and the charge for trafficking in large quantities of cannabis (over three kilos) may include life imprisonment—the severest sentence for any crime in Canada (Sunter 195). At the level of commercial trade, traffic in cannabis is treated by the law similarly to that of heroin, cocaine or methamphetamine, for example, drugs infinitely more harmful to individuals and communities. In these ways and others, cannabis continues to play the role of scapegoat, the "vicarious victim" (Burke *Grammar* 406) in the "war on drugs."

For many in biomedicine and pharmaceutical science today, the use of plant-drugs in therapeutic practice, and the agents and methods of their production and consumption, represents an outmoded and anti-scientific sub-cultural movement, and inappropriate therapeutic application and community of practice[15]. Physician and medical-cannabis authority Lester Grinspoon offers more on the dichotomy between whole-plant cannabis and pharmaceutical cannabinoids (*Medical* 72). For many in the pharmaceutical industry, he points out, whole-plant

[15] Szasz writes on the "parallels between licit and illicit drugs, licit and illicit healers, and the contest between them" in which "the deviants are persecuted and punished not only for what they *do* but also for who they *are*: defiant members of a 'counter-culture'" (65).

preparations are problematic. Though they are the originaries of all human medicines[16], plant species are mostly, so far, unpatentable, and therefore not controllable like pharmaceutical drugs (*Medical* 72).

Another challenge to the medicalization of cannabis is that smoking, as the preferred method of delivering the drug, is increasingly a taboo practice. This has arisen from greater public awareness of the powerful addictiveness and carcinogenicity of cigarette smoking. According to Hall and Room (2008), cannabis is thus guilty by association—blameworthy synecdochally, by virtue of the public disapproval of its mode of delivery. Moreover, the role cannabis plays as a valuable commodity in the illicit international drug economy only stigmatizes further its role in medicine.

The problem of cannabis in medicine is a complex socio-cultural and medico-legal problem in need of a solution. The total legalization of cannabis and, perhaps, the establishment of a free and open market for all or most illicit drugs, offers one such solution, and is the preferred option of some[17]. The staggering economic potential of a legal drugs market is an incentive and argument that, for many, would undoubtedly outweigh any non-economic arguments to the contrary. The decriminalization of possession of lesser amounts of cannabis (but with the maintenance of prohibitions on production and trafficking), a drastic policy-turnaround effected only recently by a number of countries,[18] is another potential response to the problem; while the controlled regulation (Nolin and Kenny xviii) of a legalized cannabis market

[16] See, e.g., Sumner, 2000; Ebadi, 2007.

[17] See, e.g., the *Economist* 7 March 2009.

[18] Portugal, Spain, Mexico, Argentina, Bolivia, and other countries have all recently (as of late 2009) decriminalized the possession of small amounts of all drugs.

seems most sensible to others, with state oversight and taxation of its commercial production and sale, as with alcohol and tobacco.

This last option was the policy recommended for Canada in the *Report of the Senate Special Committee on Illegal Drugs* (2003), headed by Senator Pierre Claude Nolin—a recommendation that was not followed by the succeeding Conservative government. The establishment in 2001 of the *Marihuana Medical Access Regulations* officially secured the legality of cannabis in medicine. Today, however, although the medicalization of cannabis in Canada has been underway for a decade, the process remains stalled.

The plant-drug's normalization within clinical practice will rely mostly on physicians' greater awareness and acceptance of its therapeutic value. Segal explains the methodological, and rhetorical, means by which physicians' professional opinions or perspectives may change: "Shifts in how physicians view patients, patient types, diagnoses, treatments and so on, are bound up with assorted texts, discourses and literatures, and they are mobilized by persuasion" ("Illness…" 235). As more physicians consult the growing base of supportive scientific evidence and consider, or reevaluate, the anecdotal evidence of their cannabis-requesting patients—*arguments* from personal experience attesting to the therapeutic effectiveness of cannabis—then perhaps shifts in the treatment of cannabis *as a treatment* in medicine may occur.

The Medicalization of Cannabis

Medicalization, "a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses and disorders" (Kawachi and Conrad 26), is a term used in the sociology of medicine to describe a growing tendency in Western society to reconceptualize certain widespread, though perhaps underappreciated or misunderstood,

conditions, experiences or behaviours[19]. The definition of the newly medicalized condition often coincides with the revelation and promotion of a medical treatment, usually a pharmaceutical medication, tailored to that condition (see, e.g., Conrad, 2005).

A sizeable literature on the medicalization of human *conditions* (medicalized to *illnesses*) has developed in recent decades, much of it rhetorical in approach or concern, but it seems that less work has been done on the medicalization of *drugs* (medicalized to *treatments*). Derrida asserts that "the concept of drugs" forbids the "possibility of description or certification" ("Rhetoric…" 20). As *pharmakoi*, drugs are inherently contradictory substances, potentially both toxins and treatments. With drugs, he argues, "malediction and benediction always call to and imply one another" (20).

The terms "illness" and "treatment" form a dialectical pair, such as Burke called "antinomies of definition" (*Grammar* 21). When the two terms are merged conceptually, a "paradox of substance" (21), a kind of causal tautology, is set up—the powerfully ambivalent, transformational marriage of negation and affirmation that is the scapegoat. On the logical and ontological circularity and co-implication, the "integral relationship…of convertibility" (508) inherent to such "reversible pairs as disease-cure, hero-villain, active-passive," Burke suggests that "we should 'ironically' note the function of the disease in 'perfecting' the cure, or the function of the cure in 'perpetuating' the influences of the disease" (*Grammar* 512).

The irony is greater when considering Burke's advice in terms of the current medicalized society, in which large pharmaceutical corporations employ teams of communications and advertising experts, whose job it is, increasingly, to determine and establish new medical conditions—conditions for which those corporations may already have proprietary

[19] Cf. Segal on "contestable complaints" and the prominence of "psychosocial elements" in the aetiologies of such controversial health conditions—"illnesses that exist at the borders of sickness" ("Illness… 232).

pharmaceutical cures. This is called "condition branding" (see, e.g., Conrad, 2005), and it is one of the major impetuses behind medicalization and the marketing of pharmaceutical products. An existing condition, with an existing designated drug treatment, may be redefined in more inclusive terms, either by relaxing the criteria required for a diagnosis as such, or by exaggerating the severity of the condition in order to motivate a greater proportion of sufferers to self-identify as requiring treatment, and thus seek out and purchase such treatment. Or else a new condition may be identified or distinguished, for which a pre-existing drug, one already in use to treat another, or other, condition(s), is "discovered" to be effective. Both strategies hinge on the process of "domain expansion," a broadening of the eligibility criteria for an entity's entry into a given category.

Domain expansion is defined by Conrad as a process that "encompasses claims-making work that extends the definitional boundaries of an established social problem to include similar or related conditions" (*Medicalization* 47). As explained above, such a definitional extension may involve either a medical condition, or a medical treatment; either the domain of diseases, or the domain of drugs, may be expanded. Domain expansion is a prime example of what Conrad terms the "shifting engines" of the process of medicalization. The movement to legalize and regulate the therapeutic use of cannabis—the movement to expand, thus, the category of sanctioned medical treatments—is one such engine.

As Conrad states, early literature on medicalization focused largely on the prominence of the efforts of such "professional claims-makers" ("Shifting…" 3) as doctors, social activists, or special interest groups, whose varied motivations were not necessarily commercial. These agents may have worked to strengthen and expand the "cultural or professional influence of medical authority" (4) in some cases, or, in others, to rectify perceived power imbalances within the

medical sphere. The process of medicalization has changed, however, and increasingly it is driven by the profit motives of large pharmaceutical corporations which, through aggressive techniques such as the direct-to-consumer marketing of their products, have recast the patient as a consumer in a marketplace of drug-treatment options.

Observers of these recent shifts in medicalization generally have been critical in their assessments of such developments. The medicalization of cannabis, I argue, is a movement of the earlier type noted by Conrad, one rooted in social activism. Its impetus is less one of activists' desire for bottom-line profit than of their desire for social justice, legitimacy, and personal safety. It is in this sense that I use the term. Medicalization, in this case, is largely a reaction to, and struggle against, the criminalization of cannabis that has taken place over the last century. In both processes, the core issue has been the definitional contest of whether cannabis may or may not be considered a safe and effective therapeutic substance.

Kawachi and Conrad describe what they claim are the three levels on which medicalization takes place—the conceptual, the institutional and the interactional. (27-8), and they address the variability of the kind and amount of involvement required by physicians on each level. They highlight, in other words, the differing role-value relations inhering to the physician on each level—implying, in each different case, his or her necessary assumption of a different range of personal and professional responsibilities and risks.

> On the conceptual level, a medical vocabulary (or model) is used to order or define the problem at hand; few medical professionals need to be involved and medical treatments are not necessarily applied. On the institutional level, organizations may adapt a medical approach to treating a particular problem in which the organization specializes. Physicians may function as gatekeepers for benefits that are only legitimate in organizations that adopt

> a medical definition and approach to a problem, but where the everyday routing work is accomplished by nonmedical personnel. On the interactional level, physicians are directly involved. Medicalization occurs as part of doctor-patient interaction, when a physician defines a problem as medical (e.g., gives a diagnosis) or treats a social problem with a medical form of treatment (e.g., prescribing tranquilizer drugs for an unhappy family life. (Kawachi and Conrad 27-8)

This scheme enables a clearer view of the crux of the current problem of cannabis in medicine. The problem rests, primarily, on the interactional level: doctors most often decline to fill out the required Health Canada application forms. Not because being a signatory to such an application poses a *real* threat, but because of the *symbolic* threat it seems to pose. Thus, though it is still running, the engine of the medicalization of cannabis that was started a decade ago sits in a perpetual idle, and the drug remains in a medico-legal limbo.

Kawachi and Conrad stress the physician's superior power in defining what can be considered a medical issue or concern. This is a function of what rhetorical scholar Charles Anderson (1989) characterizes as the traditionally "vertical" (13) nature of the doctor-patient relationship. It is a "rhetorical relationship," he asserts, in which physicians typically govern "all the options," exerting power over "vulnerable" patients who do not themselves act within the clinical encounter, but who are, rather, "acted upon" (13). Though the rhetorical parameters of the clinical encounter have changed significantly in the two decades since Anderson's work was published[20], the power imbalance he addresses, in large part, remains.

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[20] On the shifting dynamics of the clinical encounter, Segal writes that "[t]he physician-patient interaction is well known to be changing in many ways. […] More people now see their doctors for conditions that are chronic and complex rather than acute and responsive to a 'silver bullet'; health information is ubiquitous and much of it is sponsored, flowing to particular diagnoses. Neoliberal citizens manage their own health care in a full marketplace of health options" ("Illness…" 239).

Segal has studied the doctor-patient encounter and given special attention to the potentially important, and sometimes unconsidered, role of patients' arguments in helping guide doctors' clinical decisions. This approach is more discursive, and may mitigate against the risk some patients run of being "typecast" by physicians—of being viewed as a *kind* of *patient* (e.g., a hypochondriac; or a drug seeker), as opposed to a patient with a *kind* of *complaint* (e.g., a psychosocial disorder; or a chronically painful, though perhaps diagnostically anomalistic, physical condition) ("Illness… 237). Segal suggests that "the redirection of attention from patient types to argument types may have an ameliorative clinical effect, as a disinterested evaluation of claims to illness helps practitioners make decisions about care and treatment away from the shadow of the figure of the suspect patient" ("Illness…" 237). Currently, cannabis-requesting patients in the clinical encounter may be, or may perceive themselves to be, particularly "suspect," as a result of the stigma around cannabis.

This stigma is evident in the responses to the survey, mentioned earlier, querying doctors on their opinions about the *MMAR* and the place of cannabis in their clinical practice. Many respondents expressed the fear that they would be visited by an "influx of unwanted patients," or receive the disapproval of their peers, were their cannabis-prescribing habits to become known (in Spencer *Ottawa Sun* 12 Jan. 2008). Such a perception of risk, and stereotyping, is indicative of scapegoating rhetoric. Writing on the rhetorical construction of notions of risk and blame in the drugs discourse, philosopher Ian Hacking writes,"[t]he marijuana user, who is usually no danger, is usually put away with the filth, for he has engaged in ritual pollution" (38). The marijuana user, in other words, is an easy target for scapegoating.

As the "gatekeepers" of legally-prescribed cannabis in Canada, more physicians might do well to attempt such a "disinterested evaluation of claims" (Segal "Illness…237) made by

cannabis-requesting patients. Currently, these patients may be particularly "suspect" as a result of cannabis' ambiguous role in society today—it is both a major commodity in the underground drug trade, and a newly legal, but highly controlled and contested treatment in medicine. As such, cannabis-requesting patients may be "unwanted" by doctors and treated as a *type of patient* presenting insoluble problems, rather than as patients with *types of problems* for which they seek a *type of medical treatment*.

Segal points out that about half of all visits to doctors are by patients whose problems are found to have "no organic cause" ("Illness…" 231), and she emphasizes that the physician's role as the gatekeeper to medicine may thus frequently be a "moral project" (231). In some clinical encounters, physicians may struggle to discern whether a patient's complaints, or requests for particular treatments, are authentic or not. However, she argues that, although "[t]here may be drug dealers who feign migraine to receive prescription narcotics…it is not helpful for the diagnosis and treatment of pain sufferers in general to include drug dealers in their ranks" (238-9). In other words, insofar as they allow suspicion, personal beliefs, and patient "type-casting" to direct (or even affect unduly) their clinical judgement and activity, doctors falter in their mission of improving the health of patients.

Aside from the suspicion aroused by drug-seeking "feigners of any description" (Segal "Illness…" 232), physicians must increasingly contend with patients' complaints of "conditions that are chronic and complex rather than acute and responsive to a 'silver bullet'…" (239). These may be real health problems but, since they are caused by myriad factors hard to measure, or are as-yet unproven by empirical methods (or unascertainable within the brief time-frame of the average doctor-patient visit), their very status may be contested or denied. Similarly, patients who claim to doctors that cannabis alleviates effectively some ailment, due to the drug's

officially "unproven" status, very often have their requests for medication rejected. The official line of Health Canada is that "scientific studies supporting the safety and efficacy of marihuana for therapeutic claims are inconclusive" (Comeau 1508).

Conclusion

The issues addressed above are part of the rapidly "shifting engines of medicalization" (Conrad, 2005), which are working in some ways to realign the traditionally *vertical* rhetoric of the doctor-patient relationship, enabling a more *horizontal* rhetoric (Anderson 15). In the horizontal version that Anderson suggests, it is the dialectic "ebb and flow of language" itself that can generate "alternatives to the vertical rhetoric of 'artful persuasion'" (17). If physicians, in their clinical encounters with patients, are able or willing to foster such a dialogic mode of communication, one that "provides its participants with voices that empower them" (17), then a patient who otherwise might be received dismissively or treated prejudicially will be afforded a more amenable position from which to present his or her claims to the physician. The cannabis-requesting patient is one type of patient who would be well served by such a dialogic encounter.

Likewise, such a horizontal rhetoric can serve the goals of the physician, too. For in dealing with "suspect" patients, or those whose complaints may be contestable, the priority it gives to the patient's "*claims* to illness" (Segal "Illness… 233, emphasis added) can only strengthen the physician's position of neutrality and sharpen his or her decision-making ability. As Segal affirms, "exchanges between physicians and patients are *necessarily* rhetorical—each party seeks (not always consciously) to convince the other of something" ("Illness…" 234). In this light, greater attention to the "necessary" rhetoric of the doctor-patient encounter—to the persuasive language itself, generated dialectically during the clinical exchange—may help to alleviate for some marginalized patients "the burden of the type to which they may be seen to

belong" (229). Physicians may thus gain the trust of such patients and, perhaps, avoid their marginalization and stigmatization.

CHAPTER TWO

Marijuana as CONTAGION:

Socio-cognitive schemas in the cannabis discourse

Introduction

This chapter presents an analysis of two metaphorical instatiations of the cultural cognitive model[21] (Kristiansen and Dirven 9-10) and ritual event frame (Sørensen 169)[22] of CANNABIS-AS-SCAPEGOAT[23] prominent in the drug-policy rhetoric of prohibition: cannabis as a "gateway drug," and medical-cannabis as a "Trojan horse." I investigate how social perceptions of risk and transgression are formed, in part, by the language and concepts we use to describe our lived experiences—the quality of which depends, in large measure, on matters of relation, intention, and motivation.

In support of a dynamic theory of "embodied" linguistic meaning, cognitive linguist Peter Gärdenfors argues that "not only must linguistic information be compatible with information from the perceptual system concerning spatial relations, but our *actions* should also be considered" (59). Kenneth Burke is likewise concerned in his work with "the ultimate problem of the relation between symbolic action and practical conduct" (*Grammar* 314). He explains how such basic perceptual and spatial notions as *containment*, the "distinction between the internal

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[21] Cf. cognitive-linguist George Lakoff's explanation of the relation between his influential notion of "idealized cognitive models" and cultural, or folk models of categorization and reference ("Women…" 121). He makes the point that "[a] given person may hold one or more folk theories and one or more expert theories in areas like medicine or economics or physics," and he argues that "each theory…involves some idealized cognitive model, with a corresponding vocabulary" (121). Importantly for the present study of the controversial scapegoat figure, Lakoff affirms that it is "commonplace for such idealized cognitive models to be inconsistent with one another" (121).

[22] Sørensen describes an event frame as "a narrative structure with an initial state followed by a sequence of actions resulting in a terminal state" (Sørensen 169).

[23] I use SMALL CAPITALS to indicate the following theoretical items: cultural models, conceptual metaphors, image-schemas, force-schemas, and dynamic compound schemas (see, e.g., Johnson, 1987: 44, 62; Cienki, 1997: 9; Kimmel, 2005: 289).

and the external, the intrinsic and the extrinsic…" (47), can inform, and even exert control over, our personal identity and social activity. Cognitive-linguistics offers theoretical frameworks that are particularly apt at revealing the details of basic formal correlations that may undergird both symbolic and social actions, bridging gaps between analyses of language and practice.

My analysis integrates the theories of conceptual metaphor, image-schemas and force-dynamics with parts of Burkean rhetorical theory. I examine how affective and intentional qualities that emerge at the micro-level from particular compoundings of imagistic and force-dynamic schemas also obtain on the macro-, or socio-cognitive, level of symbolic action, where they may generate or augment various emotional and persuasive effects within discoursal and practical domains.

Force-dynamic schemas

Cognitive linguist Leonard Talmy's influential theory of "force dynamics" (2000), at its most basic, follows the movements of a TRAJECTOR (in simple physical terms, a body in motion) as it moves from a SOURCE position (an originary LANDMARK) along a TRAJECTORY (or PATH) towards a GOAL, or ultimate LANDMARK. En route, a TRAJECTOR may encounter other LANDMARKS, such as BOUNDARIES, which may prove to be either passable or impassable. As well, other TRAJECTORS may be encountered which, depending on their relative strength, may impinge, redirect, afford or facilitate the progress of the primary, or focal, TRAJECTOR as it follows its TRAJECTORY (see Oakley 207). Gärdenfors explains that, apart from relational details of direction and movement, such elementary dynamic schemas are devoid of "information about which kind of objects the trajector and the landmark are" (59). They are therefore versatile conceptual items generally applicable in the study of diverse areas of experience.

Todd Oakley, a colleague of Talmy's, has examined the multimodality of force schemata, and their role in persuasion. He claims that force-dynamic elements and patterns "extend semantically to cover meaning relative to the practical domains of the polis, the home, and worship and the exchange domains of wealth, aesthetics, and justice" (*Attention*… 206). The recruitment of force-dynamic theory for use in rhetorical or semantico-pragmatic analysis, though uncommon, is not novel (see, e.g., Oakley, 2009; Gärdenfors, 2007; Sørensen, 2007). Oakley points out that Talmy himself "anticipates the general application of force dynamics to the study of rhetoric and argumentation in the domains of discourse" (*Attention* 207).

Dynamic Compound Image-schemas

Two schema theories—force-dynamics and image-schematics—increasingly are appreciated in the cognitive-linguistic literature as mutual systems presenting a combined concern. Scholars have analyzed the primitive CONTAINER image-schema perhaps more than any other, and have identified numerous dynamic compound schemas entailed by the notion of CONTAINMENT (see, e.g., Correa-Benningfield et al., 2005; Dewell, 2005; Kimmel, 2005; Gärdenfors, 2007; Sørensen, 2007). Beyond the elementary BOUNDARY, IN-OUT, CENTRE-PERIPHERY (Johnson, 1987; Lakoff, 1987) distinctions, some examples of dynamic CONTAINMENT schemata in the literature are ENTRY (and EXIT), INCLUSION (and EXCLUSION) and ENCLOSURE (Dewell 374-83), and MERGING, SPLITTING, CONTRACTION, EXPANSION, PULSATION, EXPLOSION, DEFLATION and NESTING (Kimmel 290-1).

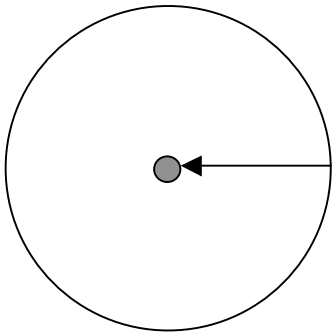
CONTAINMENT, as a sub-type of control, implies power (see, e.g., Correa-Benningfield et al. 360)—and the force dynamics of power may be experienced as either benign or malignant, depending on one's viewpoint and role, as either *agent* or *patient*, victimizer or victimized. Jesper Sørensen, a scholar of religion and a cognitive theorist, points out that "[i]n all schemata,

the element approaching or departing the CONTAINER can be understood as either positive or negative" (168). Thus, the generalized CONTAINMENT schema may be conducive (or productive) of what Talmy calls "cognitive/affective states" that "occur in association with a geometric schema" ("Fundamental…" 219). Depending on role and viewpoint, such states may be experienced either positively (e.g., protection/shelter, INCLUSION/belonging) or negatively (e.g., confinement/exposure, EXCLUSION/alienation).

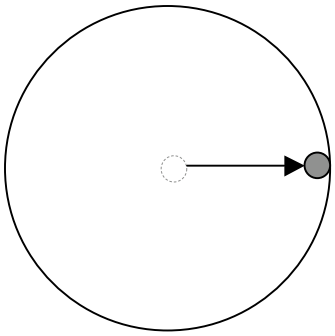
In his close examination of the force-dynamic patterns emerging from the CONTAINER schema, Sørensen acknowledges the basic but vital fact that "[c]ontainers contain something, and they have a border that can be transgressed" (166-7). His insightful book *A Cognitive Theory of Magic* (2007) outlines a series of such dynamic schemata, and explains the relevance of each one to the cognitive underpinning of different magical routines. He identifies six interactional patterns that may typically obtain between a CONTAINER and a TRAJECTOR, and depicts each one diagrammatically. They are: REJECTION, ANNEXATION, ATTRACTION, RETENTION, EXPULSION, and REPULSION (167). And he identifies CONTAGION, or "essence transfer" (102) as constituting its own socio-cognitive schema, showing it to be one of the most important schemas ordering magical practices, and mystical explanations of causality.

A Cognitive-schematics of the "Dialectic of the Scapegoat"

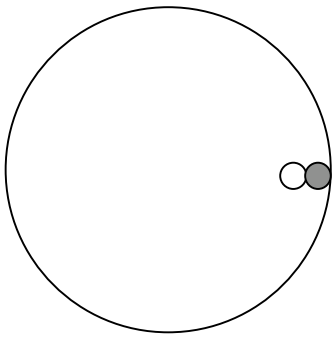
The dynamic compound schema that makes up Burke's "Dialectic of the Scapegoat" (*Grammar* 406) involves the static CONTAINER image-schema, as well as a number of force-schemas entailed by the dynamic CONTAINMENT schema, and unfolds via the following three-part process (see Figure 1). Importantly, the second stage is itself triadic, tracing the transgressive steps of *catharsis* that approach, traverse, and continue beyond the boundary: (1) the internal selection (a CENTRALIZING, or focalising function within a bounded realm or



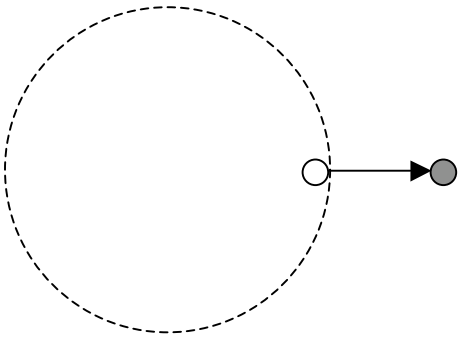
(1) CENTRALIZATION



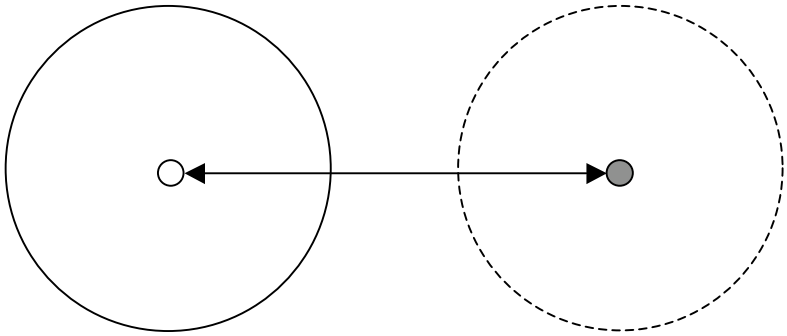
(2A)



(2B) SPLITTING



(2C) EXPULSION



(3) PART-WHOLE/
SYNECDOCHE

Figure 1
The dynamic compound schema
of "The Dialectic of the Scapegoat"

CONTAINER) of an appropriate sacrificial victim (a blameworthy focal TRAJECTOR) that is perceived or argued to be the cause or source of social problems, both "contagion" and "curative"; (2a) its PERIPHERALIZATION (following the TRAJECTOR'S assigned PATH, or TRAJECTORY, from the CENTRE to the PERIPHERY of the CONTAINER); (2b) its dichotomization, negative redefinition, or SPLITTING, the EXPULSION from the CONTAINER of the originary TRAJECTOR and the retention and reification of the substitute and, finally; (3) the establishment of a new CENTRE-PERIPHERY relation within the CONTAINER, one built in opposition to the expelled agent, the residual influence of which is thus negatively confirmed and perpetuated through a synecdochal, or metonymic, PART-WHOLE representation.

There is a prior stage of the scapegoat complex, not included above, which only appears forensically, in the erratic accusation of the scapegoat and the pursuant misattribution of blame. The scapegoat, previously unacknowledged but abiding within the group, is adduced to have TRANSGRESSED the BOUNDARY of the CONTAINER at some point in the past, and is accused of having introduced an illness or misfortune into the community at that time, polluting the body-politic. This, in other words, is the fateful moment of CONTAGION—the most fundamental cognitive schema for imputing causation in the face of adversity of unknown origin (see, e.g., Sørensen 95).

The TRANSGRESSION Schema

Talmy identifies a category of cognitive/affective state that is, I argue, characteristic of social responses to acts of transgression. He refers to an "attitude toward a schematic feature that it is unknown, mysterious, or risky." And he posits the emergence of such an attitude of risk-perception from schematic information inherent in "the English preposition *beyond*," which prompts "the further concepts of inaccessibility or nonvisibility…" (1995: 219). He notes also

that a speaker who uses this preposition "in some way regards that region of space [i.e., the distal] as being unfamiliar and the Figure located within it as accordingly being in potential jeopardy" (219). Here, in his contemplation of liminality, danger, and transgression, Talmy captures some of the essence of the scapegoat. The scapegoat is a cultural cognitive model that evokes a mysterious and risky figure in the boundary zone that is easily misapprehended, and always hard to confront.

Cognitive linguist Michael Kimmel suggests that intentionality, "[e]motion and motivation…occur as emergent properties of image-schematic compounds, because these are typically the outcome when an emotion-triggering social setting is construed as a complex scene" (303). It is the power of *liminality*—the dynamic concept, quality or ability of inter-domain transit or co-occupation—that is at the root of the "dialectic appeal" (Burke *Rhetoric* 140-1) of the scapegoat complex. *Transgressiveness* is a particular type of liminality that expresses the negative affective and evaluative meaning that attends the commission of a crime, sin, impropriety or insult. I hold that transgressiveness is perhaps the most definitive trait of the scapegoat figure itself: crosser of symbolic boundaries, bearer of both blessing and curse.

I posit a socio-cognitive TRANSGRESSION schema, an affective and intentional entailment of the more primitive spatial ACROSS image-schema (see Talmy, 2005: 217). Since TRANSGRESSION is cross-directional, iterations of the schema may be either ingressive or egressive. The ingressive iterations of TRANSGRESSION pertaining in the "gateway drug" and "Trojan horse" epithet are listed below. INHALATION[24] (A naïve youth's first-time cannabis use, risk-taking and fate-sealing); PENETRATION (Cannabis' forcible re-entry into an unprepared Canadian medical scene through an Ontario judge's 1999 ruling, or other successful medical-cannabis rulings

[24] Cf. Sørensen's statement that "[r]epresentations of forward contagion are found in practices such as inhalation, ingestion and touching …" (103).

"spearheading" the wider anti-prohibitionist agenda); INVASION (An invasion of Greek soldiers—the end result of the Trojans' acceptance and and ANNEXATION of the false "gift" of the horse, or; An invasion, or "INFLUX of unwanted [cannabis-requesting] patients" (Spencer, 2008)—the result of a physician's cannabis-prescribing habits becoming known, i.e., the result of such information ESCAPING).

The egressive iterations are as follows: STRAYING (a youth's "straying from the fold," wandering out of bounds, or spell of errancy); ESCAPE (a youth's figurative escape from the constraints of institutional or parental authority through cannabis experimentation); ABANDONMENT (a cannabis-using youth's abandonment of self-control, morals, ambition or hope); FORFEITURE (a cannabis-using youth's forfeiture of potential success, happiness and health, or forfeiture of Canada's offer to each abiding citizen of a prosperous future).

The CONTAGION Schema

On another level of analysis, both types of TRANSGRESSION (the egressive and the ingressive) may be elements of CONTAGION (Sørensen 95), which I hypothesize to be a compound schema consisting of ATTRACTION (Talmy, 1983; Johnson, 2005: 20; Sørensen, 167), DISINHIBITION, TRANSGRESSION and CONTROL (Correa-Benningfield et al. 360-1). Sørensen explains CONTAGION as "a system involving force-dynamic representations of the relative strength of the borders of two containers, of possible entries, and of the power of essence or quality transferred" (109).

My notions of INHIBITION and DISINHIBITION are generally analogous to the established force-dynamic schemas BLOCKAGE, RESTRAINT, ENABLEMENT and REMOVAL OF RESTRAINT (see, e.g., Clausner 102). The intended meaning of inhibition is that of "holding back or resisting," and the intended meaning of disinhibition is that of "letting go or relenting." The terms are applicable to, respectively, acts or states of either maintaining control (e.g., keeping a boundary intact) and

resisting an antagonistic force; or of losing or abandoning control (e.g., allowing a boundary to be broken) and succumbing to an antagonistic force. Cannabis, I hold, is understood both psychopharmacologically and socio-cognitively as a powerful *disinhibitory* agent.

In an actual biological case of CONTAGION, a pathogen (1) homes in on, or is ATTRACTED to, its targeted victim and would-be host, (2) DISINHIBITS, or works to weaken the target's resistance and gain entry, (3) PENETRATES, or TRANSGRESSES the BOUNDARY of the victim's body-CONTAINER and (4) establishes CONTROL of the victim, through a kind of ATTACHMENT (e.g., as an acute, debilitating disease-condition; or a chronic state of infection by a parasitic virus).

Figuratively, in the gateway epithet, the CONTAGION/gateway (1) offers an attractive, open and accessible point of egress; (2) disinhibits the cannabis-experimenting youth with the promise of freedom, escape, or adventure; (3) draws the youth through and beyond the gate, i.e., the youth transgresses the threshold by exiting, and; (4) establishes control of the youth, by automatically locking itself, and thereafter excluding the youth from re-entering. Literally, the CONTAGION/cannabis (1) is attractive to the youth, due to its "euphoric high" (Sibbald 2001); (2) disinhibits the youth, due to its easy availability and relative social acceptance; (3) penetrates, or transgresses, the youth's blood-brain barrier at the moment of inhalation, effecting the permanent changes of "neurochemical priming" (see, e.g., Iversen 208-9) and; (4) leads the youth to more dangerous drugs to which he or she becomes attached, i.e., the youth falls under the control of hard-drugs, becoming a lifelong addict.

Cannabis as "Gateway Drug"

The "gateway theory" claims that early cannabis use leads to the later use of, and eventual addiction to more dangerous drug. It hinges on the assertion that early cannabis use permanently

alters the brain functioning of the naïve user, triggering neurobiological and neurochemical mechanisms that "prime" him or her subsequently to seek out ever more extreme drug experiences. Its claim is that cannabis, in effect, lures its unwitting user up to its metaphorical GATEWAY, an accessible and inviting threshold, the ostensible boundary between two potential states of being: a drug-free wellness on the one side, and a drug-addicted illness on the other. These biopsychosocial *states* are understood *topologically*, via the basic metaphor STATES ARE LOCATIONS (Kövecses 135).

The validity of the gateway theory has been roundly discredited (see, e.g., Zimmer and Morgan 32-7; Nolin and Kenny 62-5; Iversen 209; Chapkiss and Webb 69; Kisely 795). Rodney Skager, a scholar of education and information studies, referring to the work of Golub and Johnson (2001), points out that "[u]ltimately the gateway theory on marijuana was shown to be false empirically, as well as logically" (307). And pharmacologist Lesley Iversen, in his recent and thorough book *The Science of Marijuana* (2008), states that "[t]he neurobiological basis for the gateway drug theory is speculative at best" (209). The theory is a case of the rhetorical fallacy *post hoc ergo procter hoc*—a mistaking of *correlation* for *causation*—and a classic *slippery slope* fallacy[25]. As a version of scapegoating, the gateway hypothesis is, to use Burke's words, an "error of interpretation" (*Permanence* 14): a false accusation and the misattribution of blame.

Overall, "gateway" prompts images and notions of boundary- or threshold-crossing. In other words, it suggests any number of possible semantic features inherent in the concept *transgression*. Though the metaphor in question is meant chiefly to dissuade young people from experimenting with cannabis, there is nothing inherently forbidding about gateways. Without mentally simulating vivid and plausible scenarios from an imagined (or known) addict's life of

[25] See psychologist Mitch Earleywine's similar rhetorical criticism of the theory (6-8).

despair and physical and psychological decay, the metaphor renders neither eulogistic nor particularly dyslogistic meaning.

The intended emotional response to the precautionary concept of GATEWAY-DRUG is mainly one of fear, and the perception of risk: fear of the loss of security, fear of the unknown, fear of the loss of hope, health, self-control and identity that is the oblivion of severe drug addiction. But also, the term "gateway" cognitively cues the call of the wild, the allure of open country—wanderlust, or the thrill of hedonistic abandon, and offers the hope of escape from restrictive routine or overbearing authority. Accordingly, proponents of cannabis prohibition who ply, in *proleptic* argument, the GATEWAY-DRUG metaphor want their young audience to hold in mind both the frightening and enticing aspects of drugs. They want the youth to exercise self-restraint, to resist the wiles of the insidious threat they believe cannabis to be, even as the adverse effects of its use are proven to be relatively minor[26]. Do they mythologize the plant, imagining in its place the silver-tongued serpent extolling to Eve the sweetness of the apple, poised at the threshold of Paradise? Prohibitionist ideology, I argue, is a dogmatics of fearful forbiddance based on a myth of original innocence and purity—peerless qualities supposedly reclaimable through the determined resistance of temptation, and the abidance of social mores.

The cultural cognitive model of cannabis as an alluring and corrupting agent—an insidious contagion, or pathogen, that gains easy control of naïve users, triggering eventual hard-drug dependency in the vulnerable youth population—still pervades the rhetoric of prohibition. And while the epithet of "gateway drug" may be marshalled less automatically today than in previous decades, the cultural model behind the dyslogistic moniker is undeniably implicit, and at times explicit, in similar recent arguments against the drug.

[26] See, e.g., Wang et al. (2008) for a review of the research on the adverse effects the therapeutic use of cannabis.

In a *National Post* article of 6 March 2008 that reads as classic prohibitionist rhetoric, then-federal Health Minister Tony Clement details what he calls the "plain truth" of what is, effectively, the gateway argument—without actually using the term.

> Drugs often described as 'recreational' are illegal for a reason: They take a terrible toll on human health. A single marijuana joint may cause as much lung damage as up to 20 tobacco cigarettes, and regular use can cause respiratory problems such as recurring bronchitis. [¶] Cocaine use can cause increased blood pressure which can lead to a stroke. It also can lead to brain damage. Ecstasy has toxic effects on the liver. Ecstasy pills often contain other damaging substances such as methamphetamine. These health effects come on top of the other devastating consequences of drug use: job loss, family disruption and criminal records. (2008)

Clement is careful to avoid making an explicit causal link between early cannabis use and subsequent hard-drug addiction followed by psychological and social dysfunction and crisis—since none has been established. Nonetheless, the string of cause–effect (i.e., drug use–health risk) relations leading up to the last sentence, and the repetition of the terms "cause," "lead to," and "effects," seems to guide the reader to his or her own conclusion: that the ordering of items in the list proceeds from present causes to future effects. And, in his last sentence's enumeration of the "devastating consequences" of drug use, the former health minister fails to distinguish between the different effects of different drugs, indiscriminately implying that any drug use concludes invariably with the personal and interpersonal ruin of the user.

Clement's initial comparison of cannabis to tobacco—and the causal link between the former and the latter vaguely implicit in the comparison—is likely inspired by a recent version of the gateway theory for cannabis put forward in a Health Canada-commissioned survey reported

on in a 9 May 2006 article in the *Canadian Medical Association Journal* (*CMAJ*). The article's authors state that "[m]arijuana is often mixed with tobacco when smoked, and there is increasing evidence that its use by non-tobacco-smoking people may be a gateway to tobacco smoking." They conclude that "marijuana use may represent a considerable future public health burden if left unchanged" (Leatherdale et al. 1399). How "often" such a drug mix occurs is not clear—a detail vital to the validity and usefulness of the survey. As well, the future public health burden supposedly represented by current "marijuana use" must actually be that of current and ongoing tobacco use, since no other acknowledged health burden is mentioned. The article's penultimate sentence, in which the authors warn that "marijuana use by former smokers may increase their risk of [tobacco] smoking relapse" (1399) is simply a reiteration of the gateway argument. According to the argument, crucially, it is not the proverbial gateway itself (i.e., cannabis) that does future damage; rather, it is that which lies on the other side of the gate (i.e., tobacco) that exacts the eventual toll.

Clement's gateway narrative begins, classically, with "a single marijuana joint" and culminates in hard-drug use, interpersonal strife, and criminality. Though Clement strives to enumerate and emphasize the *physiological risks* of drug use (those qualifiable risks for which he does, in fact, have scientific evidence), his message nonetheless possesses a moralistic tone, and comes off mostly as a warning of the *symbolic risks* of drug use. This is evidenced in the article's first paragraph, in which the cultural values of productivity and "success" are held to be the highest goals, rather than that of physical health, which is the author's ostensible main concern:

> Canada is the greatest nation on the globe—a land of hope and opportunity. We all want our children to be able to take full advantage of everything Canada has to offer, to grow into successful adults who make a valuable contribution to our society. This goal is put at

> risk when young people are offered drugs before they are mature enough to grasp the consequences of their actions. (2008)

In other words, Clement argues that socio-economic well-being, more significantly than physical well-being, is that which is most at risk when a youth experiments with cannabis.

The penultimate paragraph closely echoes the first, though here the "young person" is endowed with the *agentivity* that is notably absent above. "The decision by a young person to experiment with these drugs is not merely a 'lifestyle choice.' It is a decision to put at risk the opportunity to build the happy, prosperous life that Canada can offer them" (Clement, 2008). In the first instance, the risk posed is *extrinsic* and occurs "when young people are offered drugs" by some other, corruptive, agent. With a heavy dose of pathos, Clement attributes the threat to "heartless pushers who look for young people to hook as their existing clientele sickens and dies" (2008). In the second instance, however, the risk is seen as being an *intrinsic* one, where the youth's own conscious actions create the problem. In the first case, the youth is portrayed as a potential victim—vulnerable to the malign motives of others; in the second case, the youth is seen as a potential perpetrator—accountable for the malign motives arising within him- or herself.

Burke writes that, "with metaphors of 'the way,' the directional stresses the sense of motivation from within. Often strongly futuristic, purposive, its slogan might be: Not 'Who are you?' or 'Where are you from?' but 'Where are you going?'" (*Grammar* 31). The line separating these two models of youth is a figurative one, and relates to the locus of motivation—as either external or internal. A choice to exit through the gateway that early cannabis use is analogized to be is a "futuristic, purposive" choice, motivated from within. The line itself is the place where the risk symbolically resides, and crossing the line is a transgressive act by which a youth, succumbing to temptation, abandons self-control, rejects social values, and forfeits a

"successful" future. By crossing the line, the youth becomes transgressor. The victim becomes the perpetrator, the blameless becomes the blameworthy, the cure becomes the disease.

Medical-cannabis as "Trojan Horse"

At the 2003 International Symposium on Cannabis in Stokholm, Sweden, Antonio Maria Costa, Executive Director of the United Nations' Office on Drugs and Crime, delivered both an admission and an acknowledgement regarding the debate around the medicalization of cannabis. Debators are of two kinds, he told the audience: either those who are "serious about the medical properties of cannabis," or those who are trying to exploit the plant-drug's therapeutic benefits "as a Trojan horse to reach other goals—namely the de facto decriminalization of its production and trafficking" (in Grinspoon *Medical* 75). In this statement, Costa admits that cannabis does, indeed, have medical properties; and he acknowledges, warily, the fact that the drug's illicit commercial value and recreational popularity problematize its medicalization.

The "Trojan Horse" epithet is an instantiation, taken from Ancient Greek history and legend, of an underlying conceptual metaphor that pervades the drug-prohibitionist literature of the "war on drugs": DRUGS-AS-ENEMY INVADERS (see Montagne 20). It evokes the scenario of a fortified citadel under siege, and highlights the risk of an enemy's choice of a deceptive, or disarming stratagem of invasion. The legendary Trojan horse was a ruse—a "gift" presented anonymously at the gates of Troy that acted as a lure, enticing the Trojans to open their gates and accept the offering. The giant horse contained Greek soldiers who, once inside the city walls, waited for nightfall, then emerged from the horse and took the city by surprise.

The idea that the political and legal struggle to sanction and regulate cannabis for medicinal purposes is a ruse—a harmless-seeming issue used to obscure activists' true, more radical aims of defeating all drug prohibition laws—has existed in Canada since the beginning of

the recent era of the drug's legalized medical access in 1998. That year, following an Ontario judge's historic ruling, an editorial in the *CMAJ* took a compassionate approach to the issue, siding for the most part with physicians who supported their patients' rights to access cannabis. However, the *CMAJ* also addressed the serious concern of many of its member-physicians that the medical use of cannabis was a disingenuous rhetorical and legal ploy aimed at ending cannabis prohibition completely, and even at legalizing all drugs.

The article's author, Charlotte Gray, explains how the then-recent changes to the laws governing medical cannabis "provided a springboard for editorialists across the country…[who] argued that the harsh penalties for marijuana use contained in the Criminal Code should be eliminated" (375). But, cautions Gray, most doctors at that time "who are pressing for the release of marijuana for medicinal purposes are less quick to support general access" (375). The Ottawa physician she interviews in the article, who supports his patients' requests for medical cannabis, nonetheless "shies away from any discussion of recreational use" (375). While he "encourage[s] other physicians to show compassion for patients who will benefit from smoking marijuana," she says, he also makes it clear that he "is not interested in seeing a full-scale campaign to take marijuana out of the Criminal Code" (375).

Concerns that the medical marijuana issue is a ruse for the drug's total legalization—or even for the legalization of all illicit drugs—are not, however, completely unfounded. Numerous judicial rulings over the last few years in favour of medical cannabis have provided fodder for anti-prohibitionists of all stripes. An article in the *National Post* in June 2009 reports that "[m]edical marijuana advocates are planning a court challenge aimed at legalizing all cannabis use, in response to the latest restrictions announced by Health Canada" (Kari, 2009). The same article explains that, for part of 2003 in Ontario, "there was no valid prohibition against simple

possession of marijuana," for any intended use, stemming from "a Superior Court decision related to the flaws in the medical marijuana regulations" (2009).

Moreover, there is also evidence that drug-reformers pushing for the legalization of all drugs, have tried to ride the coattails of medical cannabis' success. In 2008, the Vancouver Area Network of Drug Users, and the Portland Hotel Society, in support of maintaining Vancouver's safe-injection site for intravenous drug users, mounted a broad challenge to "Canada's drug prohibitions and the laws upholding them" (Mulgrew, 2008) in the B.C. Supreme Court. In their arguments, writes journalist Ian Mulgrew for *The Vancouver Sun*, the plaintiffs "are relying heavily on decisions made in medical marijuana cases" (2008). So, for defenders of prohibitionist policies, the medical cannabis issue is understandably threatening and, from their perspective, the Trojan horse epithet may seem quite accurate.

The Trojan horse narrative, I argue, relies on the same basic event-frame, and the same cultural model, as in the gateway drug concept. It is a version of CONTAGION, and the "horse" is an instantiation of the scapegoat. The horse, as a mysteriously ATTRACTIVE and impressive gift-offering, DISINHIBITS the Trojans, who, in accepting the gift, lower their defences, and allow the CONTAGION to TRANSGRESS their BOUNDARY. After entry into the CONTAINER/citadel, the CONTAGION/horse takes CONTROL of Troy, and wins the war.

Conclusion

So, in the case of the gateway drug, the naïve youth accepts the CONTAGION/cannabis smoke via INHALATION—thus committing a TRANSGRESSION leading to the youth's EXPULSION from the realm of "healthy drug-free living" and the FORFEITURE of the youth's eligibility for a happy, prosperous, self-determined future. In comparison, the naïve Trojans accept the CONTAGION/horse by wheeling it through their own welcoming gates—thus committing a

TRANSGRESSION leading to the Trojans' EXPULSION from their civic stronghold and private homes, the destruction of their city and the FORFEITURE of a happy, prosperous, self-determined future for them in Troy. Both dramas unfold in a similar fashion, following the steps of ATTRACTION, DISINHIBITION, TRANSGRESSION and CONTROL; and both cases, as I have argued, are versions of the same compound schematic event-frame of CONTAGION.

CHAPTER THREE

Containing a Liminal Act:

Role and Motive in the "parallel" policy of production and supply in Canada's medical-cannabis scene

Introduction

I study in this chapter the three most active roles in the licit, and pseudo-licit production and provision of medicinal cannabis in Canada: the Designated Producer of the *Marihuana Medical Access Regulations* (*MMAR*), the leadership and suppliers of established compassion clubs, and the leadership of the sole federally licensed medicinal-cannabis factory. Using the methodology of Burke's dramatistic pentad, I identify in each case the dominant, or "featured" (Burke *Grammar* 127), term in the motivational calculus of the agent, and I consider important aspects of physical place, through analysis of the scene-act ratio. Finally, I note a self-defeating tendency in the contradictory medical-cannabis policies of Health Canada, which I claim to be characteristic of a particularly ineffectual, or "failed" version of the scapegoat figure[27].

Pentadic Analysis

Relations among the five "master terms" of *act*, *scene*, *agent*, *agency* and *purpose* known as the dramatistic pentad constitute the basic "grammatical"[28] functions of the Burkean theory of human language as symbolic action. The pentad is a heuristic that can be used to investigate the

[27] According to Burke, if a scapegoat and scapegoater fail in their dialectic at the third and final stage of *reidentification* (a re-merger along new "principles"), then, "insofar as the separation is maintained, there would be a representative action and a representative passion (which, later, in a secular terminology, would amount either to a representative illness or a representative crime" (*Grammar* 426). I contend that such a sustained separation characterizes the discourse around medical cannabis, and holds the drug-plant in its troubled state of medico-legal limbo. As a failed scapegoat, it is a substance neither fully blameworthy, nor fully praiseworthy.

[28] This means they are functionally generic—diagnostic tools applicable to any given object of study.

motives of agents in their different roles. The interdependent values of the terms are known as the pentadic ratios, and the analyst or critic (who is also a kind of social actor[29]), in adducing such values, may reveal points of potential transformation in a debate, or weigh discursively options for effecting dialectic change. Often, a single term will emerge in the analysis as dominant, and this can be a major clue to motive. Burke called this the "featuring of a term" (*Grammar* 128) in an agent's motivational calculus.

The Canadian medical-cannabis *scene*[30], in the Burkean sense, is a multi-disciplinary and controversial arena. In it, *acts* that are still controversial, in the eyes of certain groups and individuals, are performed by *agents* who are, arguably, insufficiently identified or ill-qualified in their work, and who work towards, possibly, suspect *purposes*—and whose means are provided by what some have deemed an irresponsible and questionably motivated *agency*. Marijuana, in other words, is still a taboo substance—both prohibited and permitted, existing both within the law and outside of it. As a result, those agents who carry out the act of the production and distribution of cannabis for medicinal purposes themselves continue to be viewed with suspicion, or apprehension, as social actors who perform a liminal, transgressive act.

A Parallel Policy of Production and Supply

When the *MMAR* came into force in Canada in 2001, the practicalities of pot production, for some, changed dramatically. The illicit was now licit; what had been deviant was becoming legitimized, though in a somewhat curious manner. A "Designated Producer," (DP) could now

[29] According to rhetorician Judy Segal, often "research in rhetoric of health and medicine is…itself a form of symbolic action ("Rhetoric…" 228).

[30] Burke's "scene" refers to "the background of…[an] act, the situation in which it occurred" (Burke *Grammar* xv). On the all-encompassing nature of scene, Burke famously puts it that "the scene contains the act" (3). Rhetorical scholar David Goodwin notes that scene also "includes the notion of 'place' as context, containing the values and assumptions of a group, temporally circumscribed and open to constant examination and dispute" (210).

be assigned by an authorized patient and licensed by Health Canada to grow marijuana for medical purposes, but only for that one patient. DPs require no form of technical accreditation or proof of aptitude, and their licenses are provisional and always temporary, requiring annual renewal. As a further measure of control on production, only three DPs could cooperate under the same roof. Alternatively, the patient could grow for him or herself. As a third option, the patient could send away for cannabis produced by "the only commercially-sized licensed grower and distributor of cannabis in the country (Mulgrew 230)," Prairie Plant Systems, located in Flin Flon, Manitoba.

Apart from four more-or-less significant amendments made in 2003, 2005, 2009, and 2010, the regulations remain virtually the same. Yet, despite their being in effect for nearly a decade, the *MMAR* continue to offer a policy framework inferior to that of a number of long-standing "compassion clubs." Such organizations are often registered non-profit societies staffed by lay experts in the medical use of cannabis who are committed to providing quality care for patients in a "secure environment conducive to healing"—but whose activities remain illegal, often only barely tolerated by local authorities (Capler and Lucas, 2006).

It is in this legalistic and symbolic boundary zone that operational and jurisdictional challenges have stalled, precluding the establishment of a "transparent therapeutic distribution system," a goal set out nearly a decade ago in the recommendations of the Senate Special Committee on the Non-medical Use of Drugs (Nolin and Kenny 125). Instead, the act of producing and supplying medicinal cannabis has become a dramatic example of what Burke calls "the ultimate problem of the relation between symbolic action and practical conduct" (*Grammar* 313-14). The production of medicinal cannabis in Canada remains a legally murky, liminal

domain of practice, in which agents' roles range from the precariously legal to the nominally criminal.

Agents in the Production and Supply of Medicinal Cannabis

The Designated Person

Under the terms of the *MMAR*, a physician signs a declaration, providing a confirmation of a patient's diagnosis, and authorizing a herbal cannabis treatment for that patient. The patient names a DP, who is required to pass a criminal-record check, and the landlord of the growing site, along with the other three signatories (doctor, patient, grower) fills out a particular section, or appendix, of the document. An estimated eight weeks after its submission to Health Canada's Office of Cannabis Medical Access (OCMA), the patient and/or grower receive a plasticized photo-ID card in the mail and, in an instant, a home-grown pharmaceutical cottage-industry is allowed to take root.

The ethos of the marijuana grower traditionally has been a deviant one. This is due to the long-illicit status of the drug, the unaccredited skills and species-specific horticultural knowledge inherent in the role, and his or her almost certain experience not only as a grower but also as a user and seller of marijuana. Nonetheless, in the absence of any official accreditation, this first-hand experience using and growing the drug-plant would seem invaluable in improving understanding of the mostly undocumented and under-studied differences in therapeutic effects of the numerous strains of the plant. The necessary experience and technical ability needed to cultivate high-quality cannabis is possessed almost totally by members of a deviant sub-culture—the underground world of the illicit marijuana industry. The deviant ethos of the cannabis cultivator may undergo a kind of redemptive transformation via the authority bestowed under the *MMAR*: the law-breaker becomes ground-breaker, the outsider becomes insider.

In this sense of legitimization, the master term featured most significantly in the motivational calculus of the DP is that of agency. Burke understood agency most generally as the means by which a given act may be carried out (*Grammar* 228). In addition to the instrumental meaning of the term (e.g., a pen as the agency of writing), I include within my meaning of it the social structures that enable or allow the performance of a given act (e.g., literacy as the agency of writing).

Absent Health Canada's authorization to produce cannabis, the DP's acts would be deemed criminal. I argue that the agency granted by legitimacy is the most salient feature of the operations of the DP under the *MMAR*;. The DP's production license is the sole means by which that person may produce cannabis lawfully. In other words, it is the desire for legal and occupational safety, through the legitimacy conferred by the agency of Health Canada, that is the most likely motivation for the actions of the medicinal-cannabis cultivator and provider.

Compassion Clubs

A rhetorical orientation towards process and ends can be discerned in the "Guidelines for the Community-Based Distribution of Medical Cannabis in Canada," published by the British Columbia Compassion Club Society (BCCCS). In the document, pains are taken to address procedural issues within the Society's health policy and practice, highlighting aspects of purpose and end.

The concern for patients' and workers' on-site safety is one example: "All WCB rules and regulations, city by-laws and fire codes must be adhered to. Dispensaries must be clean, follow universal precautions for infection control, and provide restroom facilities" (Capler and Lucas 19). The concern for product safety is another: "Ideally, all dispensaries would be able to obtain laboratory data on heavy metals, pesticides and biological impurities. However, under the current

legal regime there are no labs in Canada licensed to test cannabis for end-users" (17). The statement by the BCCCS that "areas of staff training should include: the effects of the variety of strains on different symptoms and conditions, dosage, potency, tolerance, dependence, ingestion techniques, side-effects, safe use techniques, [and] potential drug interactions…" (19) provides a third example of the Society's purposive orientation, and serves the Society's goal of providing safe, effective medicine to patients.

Senator Claude Nolin identifies this purposivity, noting the "laudable motives" of the BCCCS of "distributing cannabis to patients in order to alleviate their suffering" (125). The term that features most prominently in a calculation of the motive of compassion clubs, then, is purpose, or end.

Prairie Plant Systems, and Canada's Former "Marijuana Mine"

The small community of Flin Flon, Manitoba was, for nearly a decade, the self-proclaimed "Marijuana Capital of Canada" (Naylor, 2008). Between 2001 and 2009, it was home to Canada's internationally renowned "marijuana mine" (Dowd, 2009), the federal government's industrial-scale facility for the cultivation of medicinal cannabis. The Saskatchewan company Prairie Plant Systems (PPS) ran the facility under exclusive contract, operating in an abandoned section of the Trout Lake Mine. In an article in the *Flin Flon Daily Reminder* by local journalist Jonathon Naylor, PPS's president, Brent Zettl, proudly explains how the controversial crop was grown in the "state-of-the-art subterranean location," which provided a "fully controlled and highly secure" environment (2008). Zettl's emphasis on the physical attributes of his facility reveals a featuring of the scenic element in a calculation of PPS's motives.

While Prairie Plant Systems is still the sole Health Canada-licensed cannabis factory, it no longer cultivates in Flin Flon, a town that lost its claim to fame after a disagreement with PPS's

landlord, Hudson Bay Mining and Smelting. The company has moved operations to an undisclosed location, and Zettl concedes that health department officials asked him not to divulge the whereabouts of the new "Marijuana Capital of Canada."

While the controlled environment and tight security offered by PPS's underground location had been the main factors behind Health Canada's original choice of that company, such site-specific strengths were never enough to earn PPS the respect or patronage of most Canadian licensed medical-cannabis users (Naylor, 2008). Fewer than a third of the country's licensed users obtain their cannabis from PPS (Edwards, 2010). Although his cultivation facility is certainly "fully controlled and highly secure," "one of Zettl's biggest challenges," explains Naylor, has always been poor "public perception" (2008).

This is a case of what rhetorical scholar Jerry Blitefield calls the "transubstantiation of place," whereby place becomes "not just a site for discourse but a medium *of* discourse, an outward expresser of will and resources: place as agent" (121, original emphasis). As scenic-agent, or agentive-scene, a material place—a building or location—may come to perform symbolic actions on the social stage, insofar as its presence is perceived as looming too conspicuously, precariously, or imposingly within particular scenes of practical or symbolic action. Thus, a building may itself invite or provoke rhetorical responses from supporters and detractors alike.

Zettl's company, explains Naylor, "has endured years of media reports portraying the Flin Flon marijuana as too weak or otherwise unsuitable" (2008). In the past, Zettl had complained publicly that such claims were untrue and unfair, and taken issue with journalists he says had interviewed only "a minority of dissatisfied patients without giving coverage to the vast majority who are pleased" (2008). He also blames the bad reputation on competitive medical-cannabis

cultivators from B.C. who "are really feeling threatened" by PPS's effective monopolization of the nascent market. At an event in 2007, writes Naylor, Zettl had complained publicly that rival growers were simply "protecting their turf" by criticizing his product and operations:

> It's a marketing thing, so they can make some wild claims and in the meantime, Health Canada does not respond because they don't think it's worth responding to. And then what happens? The media report goes out and then everybody sees only a lie or the posture or the allegation. They don't see the outcome or the other side. (2008)

Significantly, he attributes part of the blame for PPS's enduring publicity challenges to his own employer's lack of support.

Some locations can effectively become rhetorical "double-agents"—symbolic facades of the very "thing contained" (Burke *Grammar* 3) within them, playing the role of the very thing they are not[31]. Canada's "Marijuana Mine" was just such a double-agent. Zettl admits that the physical security and environmental control his facility offered—the effectiveness of the place at both inclusion and exclusion—was the most valuable asset of his business. This substantiates his belief in the "power of place as a double-edged container" (Blitefield 120).

The Scene-Act Ratio, and the Ambivalent Power of Place

In his treatment of the scene-act ratio, Blitefield argues that place, or physical location, as perhaps the most fundamental component of scene, may not only "contain the act" as Burke says (*Grammar* 3) but may also perform the act, as it were, standing in superficially for the very drama it contains. Blitefield's main point is that the very "power of place" (120) held both

[31] Blitefield restates Aristotle's affirmation that "place is indifferent to its contents, because it will hold water as impartially as it will hold wine…" (Blitefield 119).

physically and symbolically by some buildings ironically may render them all the more vulnerable to those who would see them as targets of protest, vandalism or social criticism.

Containment is a type of control, and control may be either benign or malignant. Protection and captivation are two sides of the same coin, as are attachment and support, inclusion and exclusion. Elaborating Burke's dramatistic model of action, Blitefield imagines two playhouses, separated from each other in terms of physical structure, and in terms of symbolic structure:

> The power of place is a primary rhetorical concern, but it is also a primary political concern, for the power to exercise a place, to control a place, clearly determines the discourse which can transpire within: robust power imperceptibly ensures air conditioning, soundproof windows (if windows at all), and thick walls; and undisturbed performance. Marginal power has to contend with Harley Davidsons and the corruption, even interruption, of delivery. (120)

Blitefield writes about theatrical operations, of course, where "performance" and "delivery" refer to the production of a play, and "corruption" and "interruption" refer to the penetration of negative external interferences such as noise or air pollution.

However, his analysis of the dialectic of place and power (i.e., scene and act) could just as well be used to contrast the marginal power seated in the home-based growing facilitiy of the average Designated Person, or the unlicensed supplier to a compassion club, with the robust power vested in the "state-of-the-art subterranean location" (Naylor, 2008) that was Prairie Plant Systems' former Flin Flon cultivation site. In this case, the performance and delivery would refer to the production of medicinal cannabis, and the interruption could refer to a police (or criminal) raid of a medical grow-operation or compassion club. The corruption could refer to the

infiltration of the *MMAR* by criminal elements, and the selling of medicinal cannabis to a person not truly medically elegible.

Both of these scenarios may occur under the present parallel policy of medicinal cannabis production and supply. Such violations of the terms of authority undermine the legitimacy of the entire policy framework. Rielle Capler, for the BCCCS, explains that "[t]he biggest security risk to the BCCCS' cultivators and supply of cannabis comes from law enforcement officials." Senator Claude Nolin confirms the reality of such interruptions: "Because they are operating in a grey area, the people involved in these [compassion] clubs are subject to prosecution and have in fact been prosecuted" (Nolin and Kenny 125). Capler bemoans the lack of legally viable "options for production facilities, such as greenhouses" (9), which would reduce operational expenses for the clubs' suppliers (but which would also increase operational risks). As it is, Capler acknowledges, compassion clubs must pay "black market" (9) rates for their merchandise. Despite this, she says, most clubs offer their cannabis "at or below 'street' prices" (9). As regards the legitimacy of the activities of DPs, a recent article in the *Regina Leader-Post*, emphasizes "the opportunity for misuse of the system," and cites an RCMP investigation "identifying 40 cases in which licensed growers were also trafficking marijuana for profit" (Edwards, 2010).

For Blitefield, "the ability to control place as a site of inclusion, coupled with the power to control place as a site of exclusion, will determine the potential rhetorical parameters of that place" (120). As concerns the power of place held by the Designated Persons, and represented by the roughly 4,000 legal grow-operations they run—such control appears controversial, and increasingly contested.

An article of 27 October 2009, by Paul Henderson for the *Chilliwack Times*, reveals that such organizations as The Fire Chiefs' Association of B.C. "have…concerns…that no one knows

if the growers are adhering to building codes, or if safety measures are in place, meaning legal grow operations can at time [sic] be indistinguishable from illegal ones" (2009). Similarly, "[t]he city of Surrey, B.C.," announces an article published a month earlier on the website of the Canadian Broadcasting Corporation "wants Health Canada to help municipalities regulate medical marijuana grow-operations, because fire and police officials have no way of knowing when they're dealing with grow-ops that, even when legal can still be dangerous" (CBC, 2009). Such reports reveal that the power of place held by Designated Persons, a function of the agency vested in them by Health Canada's authorization, is an intimidation to local law enforcement and other community officials.

Blitefield remarks that "place, with its ability to physically include/exclude, is by its very being already an instantiation of power," but points out that "the power in place can remain intact only so long as its power is greater than that of whatever power(s) may challenge it" (120). The power to grow cannabis for patients is a power the DPs, for the time being at least, still maintain—but only tenuously. "Dissent out of place," stresses Blitefield, "is nowhere, and hence nothing: only place can bring discord into material being…" (121). In other words, for protest to matter most, it is best directed at a physical target. Without the knowledge of the whereabouts of licensed grow-operations, local officials are powerless to manifest effectively their opposition to such facilities, and therefore their discord remains relatively immaterial, their voices of dissent directed purposively yet aimlessly, futilely, at invisible targets.

Place, as the container of an act, may stand as the literal and symbolic bastion of the rhetorical and political power held by the agents operating within that place. But, by a potentially critical public's very awareness of its physical presence and location, place may also present

itself, and the agents within it, as a target vulnerable to criticism. In this way, place ironically may come to undermine the very power it is designed to embody and enforce.

In this light, too, it is no surprise that Health Canada has asked Brent Zettl to keep secret the new location of PPS's cultivation facility. Without the public's awareness of the place where the government's medicinal cannabis is produced, the power vested in that place remains more vital, less vulnerable to criticism. So, insofar as the physical location of the medicinal-cannabis production facility is not made public, the power a producer holds over that place of production (the scene containing the act) remains intact.

Health Canada's "Suicidal Motive"

The government treats the cultivation of cannabis as if it were an extremely dangerous act that produces inherently dangerous goods—hence the primacy of concern for the physical security of PPS's subterranean production site. And it does so even while producing and selling cannabis as a medicine to sick and dying patients, and allowing thousands of anonymous Designated Persons to cultivate it privately, without oversight. Health Canada betrays its belief that cannabis is not truly a medicine by keeping literally underground, and operationally out of sight, a commodity that is usually part of the figurative underground illicit economy.

Considering the aetiology of the *MMAR*[32], it is unsurprising to discover that the department essentially has been treating the medical-cannabis program as a "sacrificial lamb," setting up the participants therein (including PPS and DPs) as rhetorical straw men[33] doomed to fail, and intended by the government to do so. Thus, authorized cannabis-using patients or licensed

[32] A series of judicial opinions forced a reluctant Health Canada into the marijuana business in 2003.

[33] Merriam-Webster OnLine defines "straw man" as "1): a weak or imaginary opposition (as an argument or adversary) set up only to be easily confuted; 2): a person set up to serve as a cover for a usually questionable transaction" (<http://www.merriam-webster.com/dictionary/strawman>).

medicinal-cannabis producers may be viewed with suspicion by a bureaucracy that resents the existence of such people within the health system, but that is obliged to deal with them nonetheless.

The contradictory mixture of the rejection and acceptance of medical cannabis by the federal health department is typical of scapegoating. Politicians and bureaucrats may comprehend the drug as a necessary, though perhaps onerous, regulatory challenge, an obligatory, if problematic, addition to the category of therapeutic agents. Derrida explains the "supplementary" ("Plato's…" 135) function of scapegoats, or *pharmakoi*, as a "parasitic" (135) dynamic. This is homologous to the notion of the scapegoat as a contagion, or corrupting agent. Arguing from the perspective of the prohibitionist, Derrida describes the *pharmakos* as "that dangerous supplement that breaks into the very thing that would have liked to do without it yet lets itself *at once* be breached, roughed up, fulfilled, and replaced…" (135). The Canadian Criminal Code itself (not to mention the terms of binding international drug treaties) is that "thing" which, from the prohibitionist's perspective, "let itself at once be breached," through the forced establishment of the *MMAR* by an activist judiciary, and the health department's subsequent, if recalcitrant, acquiescence to, and regulation of, medical cannabis. The feeling of many in the current Conservative federal government is that medicinal cannabis is an explosive threat that calls for tighter measures of containment and control.

In his discussion of certain occasions of breakdown in the purification ritual that is the dialectic of the scapegoat, Burke addresses such a retaliatory self-destructiveness. These occasions of rupture in the final stage of the social ritual (the synecdochal, part-whole function of representation and substitution) can be understood to indicate the presence of what are, in effect, defiant scapegoats: victims withstanding and disproving their own victimization, and reaffirming

membership with the group on their own terms. In this way, proponents of medical cannabis may be considered to be defiant scapegoats who stymie attempts at their victimization. Burke writes that, "[w]here the principle of division is frustrated, …the discords must again be faced *within*. […] [I]nsofar as ritual transference of guilt feelings to the scapegoat is frustrated, motives of self-destruction must come to the fore" (*Grammar* 408). Elsewhere, Burke calls this the "suicidal motive," the frustrated urge of a would-be scapegoater thwarted in the attempt, who is "gnawed by resentments" that can "no longer be released in outward contest" (*Rhetoric* 5).

Such a hypocritical stance, or suicidal motive, is alluded to in a 5 December 2006 article by Pauline Comeau in the *CMAJ* reporting on the federal government's confusing, and rhetorically telling, decision to cancel the Medical Marijuana Research Program. The decision was ironic, given that the "unproven" status of cannabis as medicine is a designation due to an information deficit born of a long-term ban on research on, and clinical usage of, the plant-drug. So, even as it extended, and later increased the value of, its contract with PPS for that company to continue producing medical cannabis for sale by the government, the very same government cancelled its written commitments to carry out research on that very drug, the uncertainty over which is a result, merely, of an insufficiency of current published research. Comeau explains that "without more data, doctors will remain reluctant to participate. Patients, in turn, won't get legal access, and the grow-op could be indirectly choked" (1508).

In its paradoxical conception of, and policy concerning, medical marijuana, Health Canada treats the drug as a scapegoat—both dangerous Controlled Substance (*Controlled Drugs and Substances Act*) and *de facto* Natural Health Product (Health Canada "Supply…"). Implicitly, the federal government regards medical marijuana as what Burke calls a "representative crime" (*Grammar* 426). For others, however, it represents a treatment option that remedies the

"representative illness" (426) of what they see as an increasingly "pharmacratic" (Szasz 125) biomedicine.

Conclusion

Ethical, rhetorical, and legal disputes continue to pose challenges to the operations of the various agents within (and parallel to) the framework of the *MMAR*. It is exceedingly difficult for both licensed and unlicensed cultivators and suppliers of medicinal cannabis to effect a balance between the official practicalities of their roles and the unofficial, symbolic values (or dangers) assigned those roles publicly. Strong disagreements endure between some agents in the medical-cannabis scene, owing chiefly to the incommensurability of values and disparity of motives of hard-liners from both sides.

To the extent that the scene "contains the act" (Burke *Symbols* 152) of producing medicinal cannabis, the production facility itself emerges as the controlling factor, with physical place as the locus and determinant of a grower's power, both rhetorical and political. Overall in the debate, perceptions of risk, and expressions of suspicion and cynicism have discouraged collaborative or discursive attempts at resolving the medico-legal dilemma and drug-policy problem that medical cannabis continues to pose.

CONCLUSION

I have maintained throughout this thesis that the issue of cannabis in contemporary Canadian therapeutics remains a social problem and medico-legal dilemma that is best understood in terms of the "representative ancedote" (Burke *Grammar* 59) of scapegoating. Prohibitionist rhetors in the cannabis discourse systematically employ terminologies of risk, harm, transgression, and blame in their treatment of the drug and those who use it. Cannabis is portrayed by its most outspoken detractors as a dangerous toxin with no accepted medical properties, and those who tout its therapeutical benefits implicitly may be regarded with suspicion—as deviants driven by questionable or malignant motives. Paradoxically, however, cannabis nonetheless remains sanctioned for therapeutic use in Canada, and the adverse effects of its use have been shown to be lesser than those associated with many commonly used pharmaceuticals. Thus, it is both a dangerous illicit drug and a legally accessible therapeutic agent with an "acceptable safety profile" (Wang, et al. 1678).

I argue that cannabis prohibitionists' conception of the plant-drug as a predominantly harmful substance, the medical utility of which must either be nonexistent or misconceived—is not representative of its subject matter. It is what Burke called a merely informative anecdote, an unduly biased or simplistic picture of reality that is "unsuited to the illumination" (*Grammar* 60) of the complex properties of such a liminal substance. By the same token, some of the more fanatical proponents of cannabis may also fail in their symbolic actions at representativeness, insofar as their portrayal of marijuana is a rhetorically motivated deflection of the negative aspects of the usage of, and traffic in, the drug.

As a representative anecdote, the scapegoating complex, though implicitly tragic, nonetheless faithfully accounts for, and enables the expression of, the paradoxical qualities

embodied by cannabis in contemporary society. In its aptness at rendering both dyslogistic and eulogistic portraits of its subject, such an anecdote has, as Burke puts it, the "necessary scope" of representation for the appropriate determination of its subject matter. In other words, the terminology of scapegoating, in analyzing the ambivalent role of cannabis today, "meets the needs of reflection" (Burke *Grammar* 59). Following Burke, C. Allen Carter states that scapegoating is, largely, a dialectic "function of the pluses and minuses of symbolic language" (21). Any progress towards resolving the dilemma of the role of cannabis in medicine necessarily will, thus, require rhetorical (and therefore conceptual and linguistic), as well as socio-political and legal, efforts.

Judy Segal explains that, although the work of the rhetorical critic of health and medicine is "essentially descriptive," it may nonetheless grow from a "moral purpose" ("Rhetoric…" 228). Such work, she writes, is "itself a form of symbolic action," and may be spurred by the critic's desire to be "useful" and "ameliorative" (228-9). It is in this spirit that I have attempted this description of elements and agents in the medical-cannabis discourse. This work represents my own symbolic contribution both to the rhetorical study of medicine and drugs, and to the Burkean study of human motivation, and it has the aim of improving the understanding of a complicated issue.

In a commentary piece in the *CMAJ* appearing in 2000, in the early days of cannabis' medicalization, Drs. Perry Kendall and Erica Weir propound the virtues of the drug-policy tenets of harm reduction, and deplore the fact that Canadian cannabis policy is "formulated principally by prevailing opinions and shifting values rather than by reason and evidence" (1687). They recommend "bridging the polarities of prohibition and legalization…, intuition and information," and they stress that doctors, as gatekeepers, have "a responsibility to demonstrate temperance, to

bridge internal polarities between treatment modalities and to moderate the extremes of the debate with evidence, advocacy and compassion" (1687).

Eight years later (2008), however, physician and medical-cannabis proponent Wayne Hall bemoans the enduring polarization and politicization characterizing the cannabis debate. He admonishes that "the temptation to focus on adverse health effects needs to be balanced with potential positive effects of cannabis use," and regrets that "research into any 'balancing' public health benefits is extremely rare" (158). My claim is that those medical professionals, legislators and bureaucrats who manage a more balanced and dispassionate approach to cannabis policy, by "[d]ecoupling cannabis from political discussions" (158), increase their chances of achieving successful, or at least sufficient, resolutions to the challenges attending the drug's medicalization.

Segal explains that a rhetorical critique "may begin with a sense of a problem, perceived as discursive in nature, that might, if properly described, bend to a solution also discursive in nature" ("Rhetoric…" 228). Though it is played out in the boundary zone between medicine and law, the persistent dispute over the therapeutic use of cannabis, I maintain, is a problem that is properly understood as conceptual, discursive, rhetorical, and socio-linguistic in nature. I have argued in this thesis, and hopefully demonstrated, that techniques of rhetorical analysis and criticism, as well as those of cognitive linguistics, may be valuable in the study of such contentious matters as drug-policy reform and the shifting public perception of risk.

Rhetorical analysis and criticism offers techniques for constructing symbolic bridges between the polarized positions of disputants in an aggravated or protracted debate. According to Segal, "[r]hetorical study assumes and begins from complexity" and "suggests a means of living with the fact that a revisable knowledge is medicine's only possible currency" (*Health* 156).

Such a discursive approach may be useful in establishing a balance in what Hall calls the "inflationary–deflationary dialectic" of the medical-cannabis discourse, "in which cannabis problems have been both demonised by moralists and belittled by pro-cannabis organisations" (158). For certain, such an approach would help to start clearing the air of the unfriendliness that has troubled the political realm of the discourse for so long between those who still hold that the drug-plant is more malignant than benign, more useless than useful—and those who believe the opposite. The aim at all levels of discussion should be to develop an evidence-based, measured, and consistent policy and practice, in which the therapeutic use of cannabis would be de-stigmatized, and managed more objectively under the law and within the clinic.

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